The Patient Protection & Affordable Care Act

Impacts & Opportunities

June 17, 2010,
Workgroup 2 - Iowa Legislative Health Care Coverage Commission
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Presentation
Overview

- Presentation is intended as an **overview** of the PCCAC.
- Many specific details of the legislation remain to be determined by the US Dept. of Health & Human Services thorough regulations or directives.
- Reform will differ across states depending on existing statutes & regulations and insurance market structure.

2010 Federal Legislation

- Patient Protection and Affordable Care Act (PPACA) – March 23, 2010.
- Health Care Education and Reconciliation Act – March 30, 2010.

✓ Collectively referred to as the “Affordable Care Act” (“ACA” or “PPACA”).

✓ Generally characterized as both **comprehensive** and **incremental** in scope.

PPACA

Comprehensive Characterization

- Promotes major changes in how insurance is bought/sold and regulated.
- Looks to change the way health care is delivered and paid for.
- Ultimately is financed through new fees & taxes and fines & cost reductions.

PPACA
Incremental Characterization

- 10 year implementation schedule.
- Scores of regulations specifying the details will need to be drafted, commented on, and eventually adopted.
- Multiple new governmental agencies, commissions, committees & offices will be needed to administer the regulatory scheme.
- Numerous pilot & demonstration projects will be funded to help in providing future directions.
- Reorganization of the delivery system at the federal & state level will require change to existing laws.
- Lobbyists and legislators re already discussing how to modify the PPACA as others challenge it in the courts.

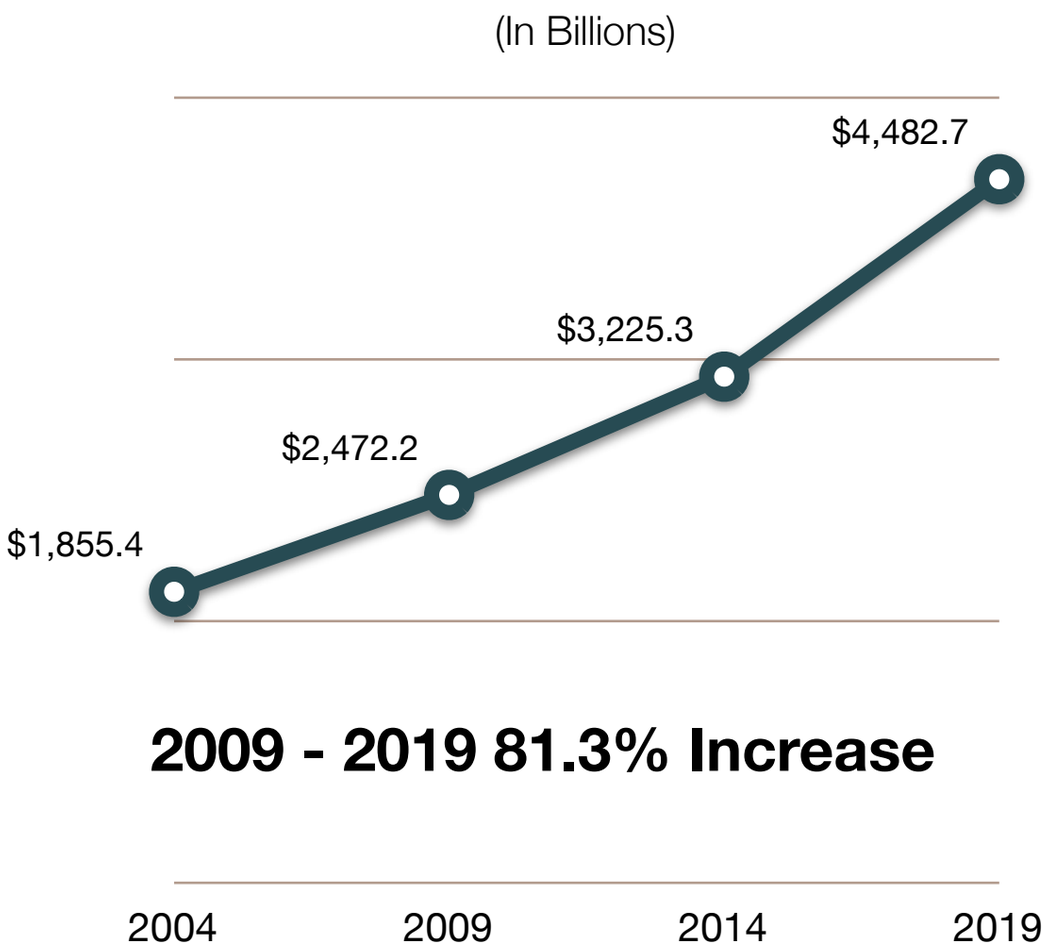
PPACA
Ultimate Characterization

- In Washington and every statehouse the conversation will be changing from:

"Should we pay to cover these people?"
to
"How do we pay to cover these people?"

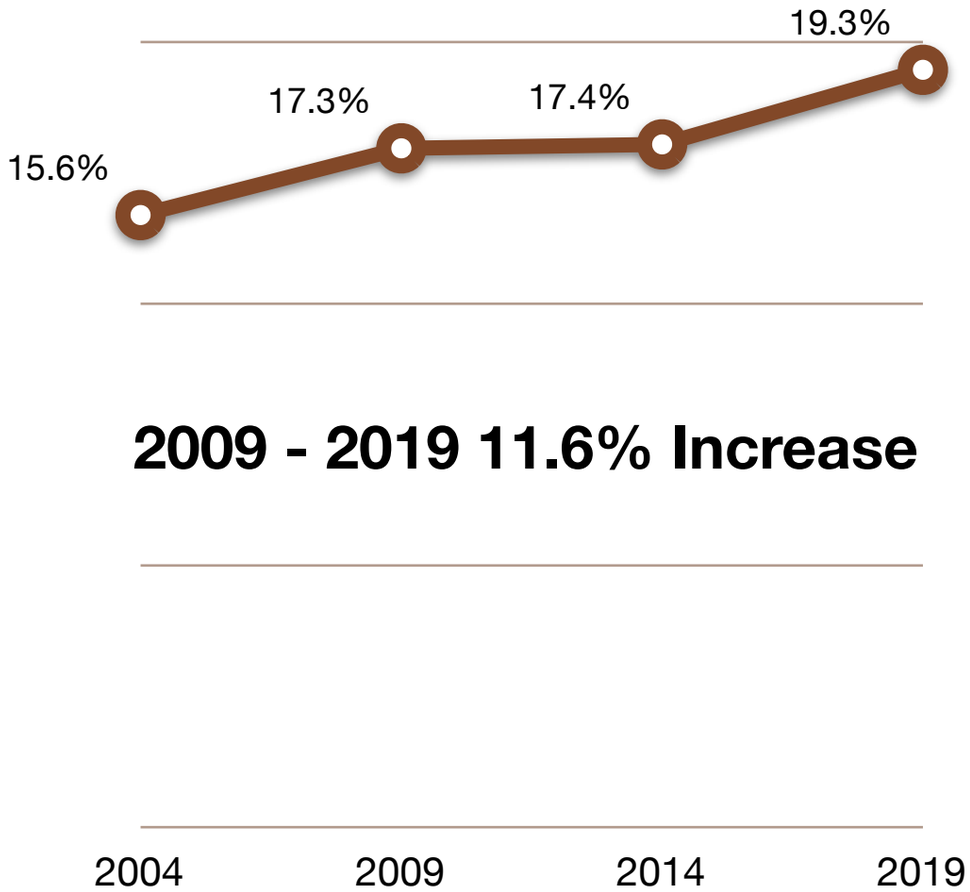
Public Program Expansion and Eligibility
American Health Care Cost Trends

National Health Care Expenditures



2009 - 2019 81.3% Increase

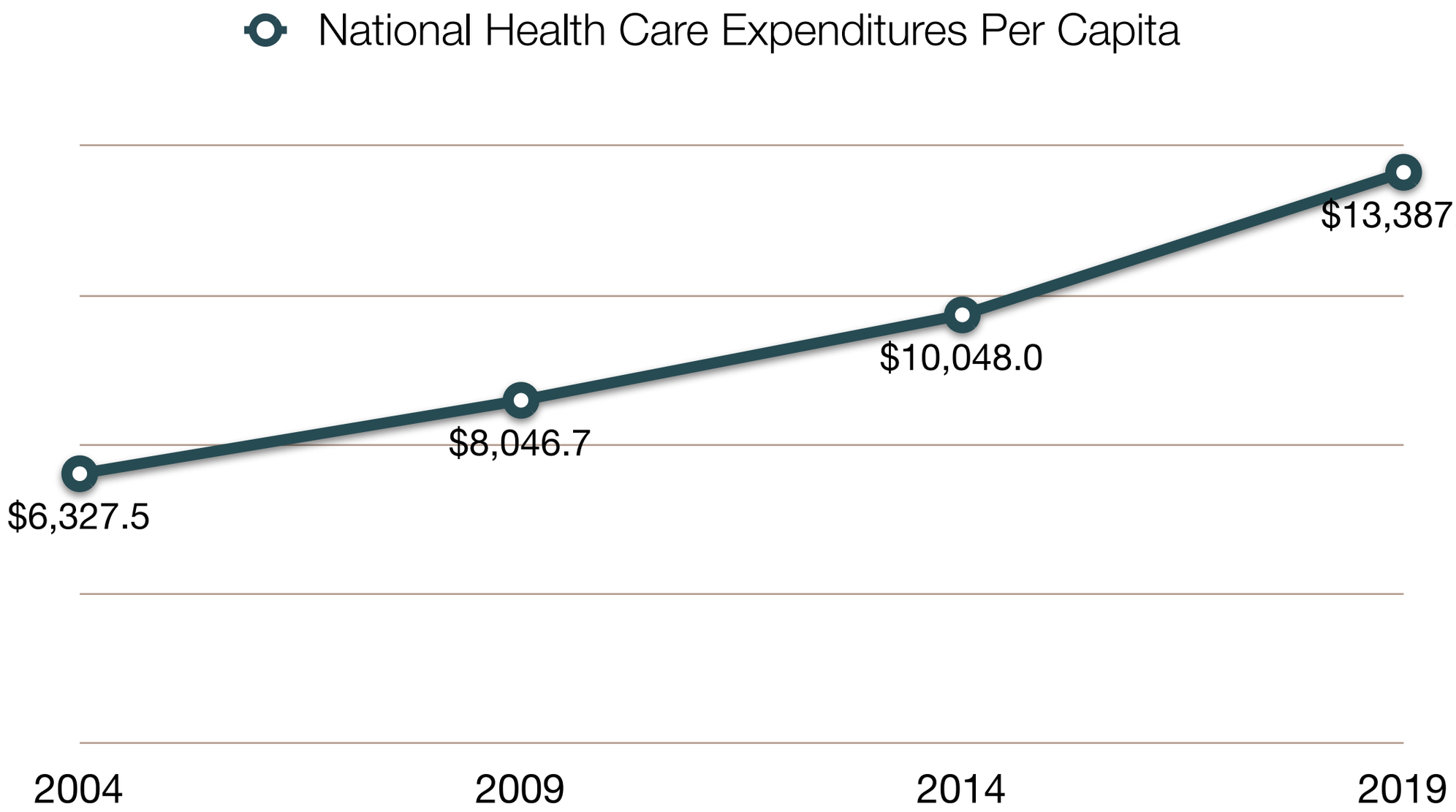
National Health Care Expenditures as a % of GDP



2009 - 2019 11.6% Increase

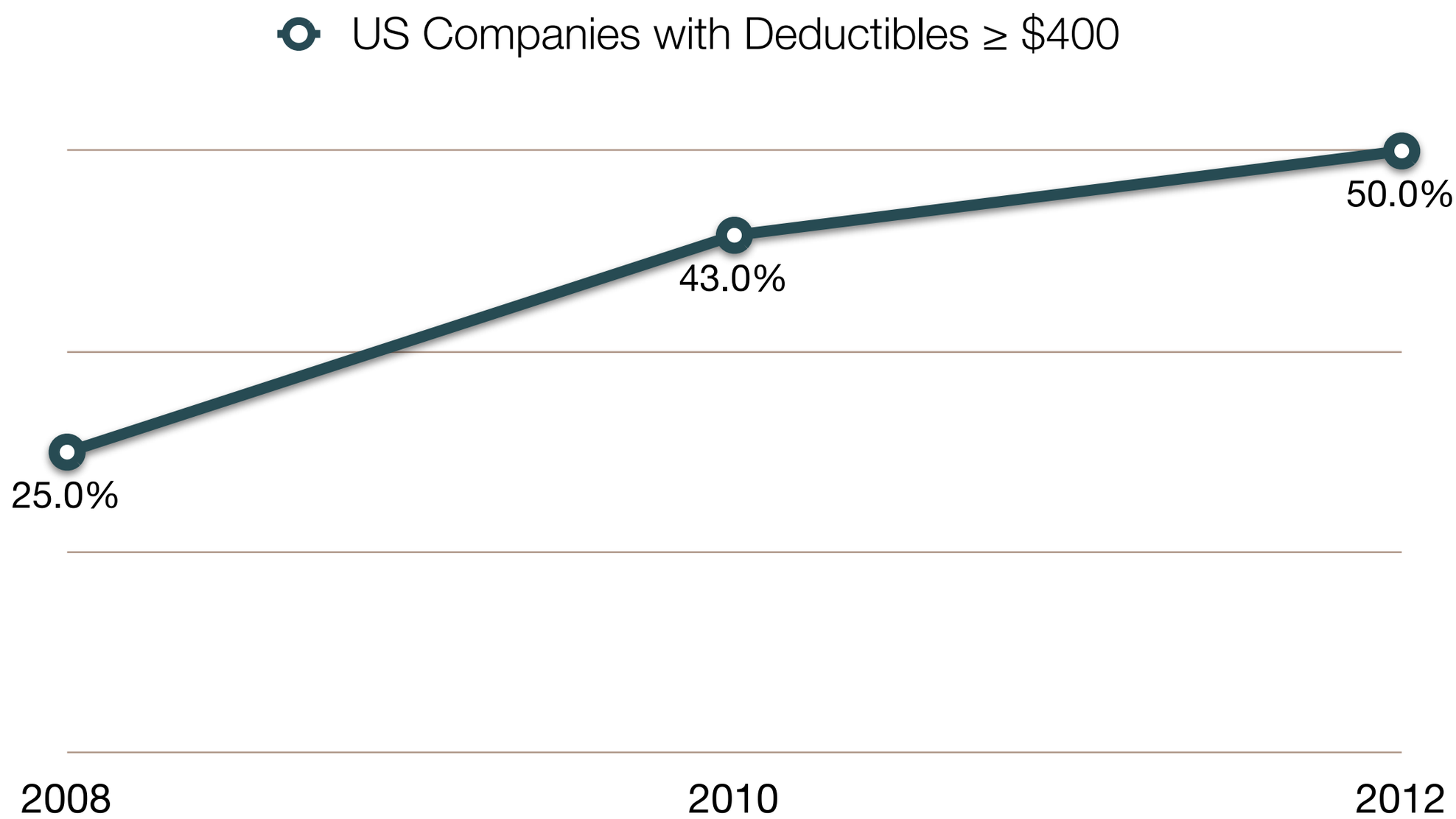
Source: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2004-2019
Available on-line at www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf

Public Program Expansion and Eligibility
Per Capita Health Care Cost Trends



Source: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2004-2019
Available on-line at www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf

Public Program Expansion and Eligibility
Health Care Cost Trends – Deductibles



Source: http://www.latimes.com/business/nationworld/wire/sns-ap-us-2011-health-costs,0,6048068.story

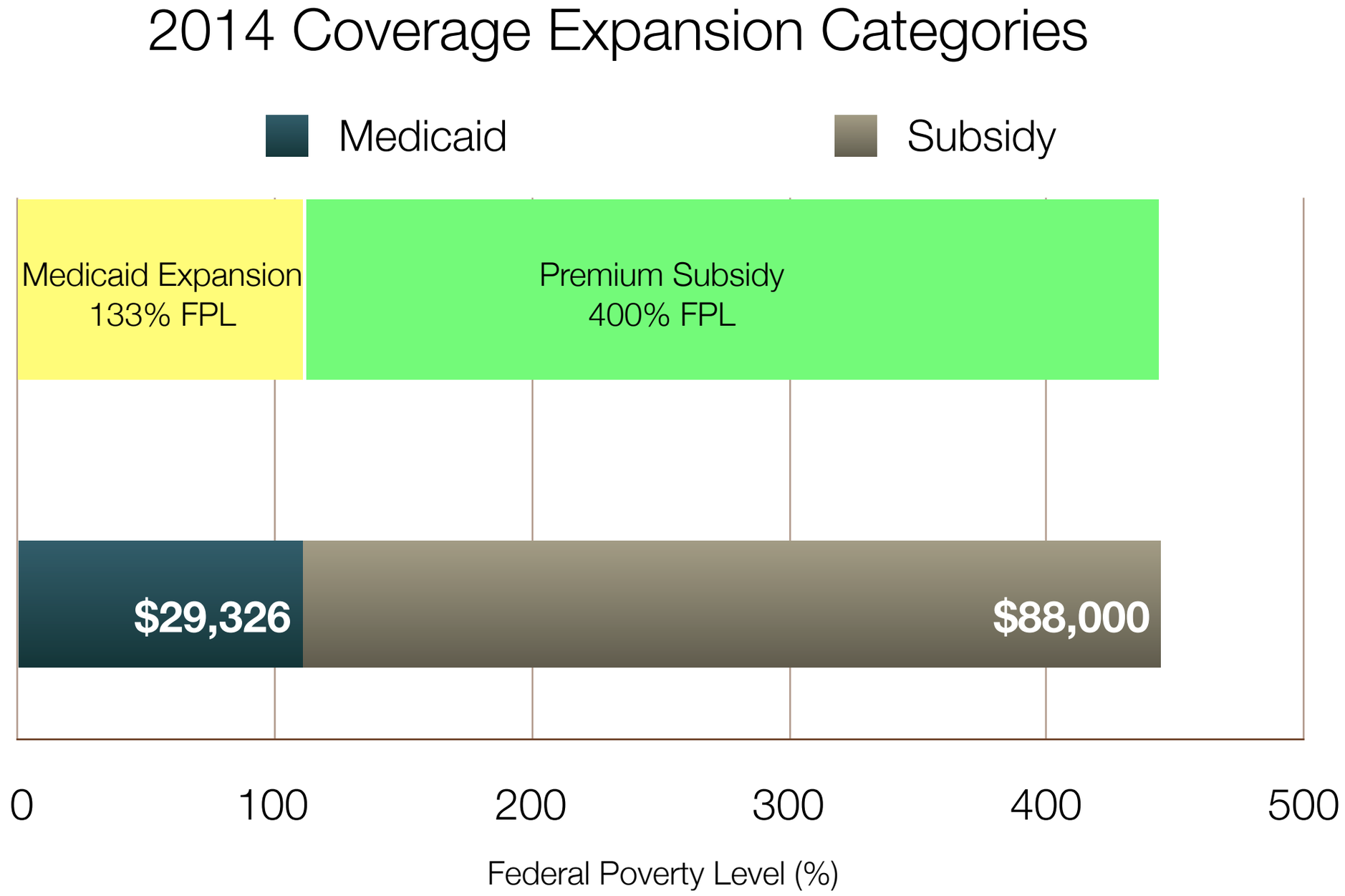
PPACA
Organizational Scheme

- Title I: Quality Affordable Care for All Americans
- Title II: Role of Public Programs
- Title III: Improving the Quality & Efficiency of Health Care
- Title IV: Prevention of Chronic Disease & Improving Public Health
- Title V: Health Care Workforce
- Title VI: Transparency & Program Integrity
- Title VII: Improving Access to Innovative Medical Therapies
- Title VIII: Community Assistance Services & Supports
- Title IX: Revenue Provisions
- Title X: Strengthening Title I

PPACA
Big Picture Items – Iowa

- Expands Medicaid eligibility to 133% FPL (2014)
  - ✓ Coverage extended to childless adults.
  - ✓ Increases federal match for new enrollees: 100% first 3 years, 90% by 2020 and beyond.
- New regulations on private insurers
  - ✓ Private health insurance companies must report the percentage of premium dollars spent on health care
    - Rebates begin in 2011 for <80 - 85%
    - Plans may be excluded from exchange for “excessive” premium increases
- $11 Bil. to Community Health Centers.
- 2011 Medicare will provide free, annual wellness visits & personalized prevention plan.

Public Program Expansion and Eligibility
Medicaid Expansion & Premium Subsidies



Public Program Expansion and Eligibility
Additional Enrollment Estimates

Impact of Reform on IA Uninsured Populations
Increase in Enrollment in 2019 Relative to Baseline
(Lower Participation Assumption)

Total New Medicaid Enrollees	114,691
Previously Uninsured Newly Enrolled	74,498
% Decrease in Uninsured Adults	44.1%
Baseline Medicaid Enrollments	452,614
% Change in Enrollments	25.3%

Source: Holahan, J. & I. Headen. Medicaid Coverage & Spending in Health Reform: Nat'l. & State-By-State Results at or below 133% FPL. May 2010. Urban Institute.

Public Program Expansion and Eligibility
Additional Spending Estimates

Additional Spending in Iowa From PPACA 2014-2019
(Lower Participation Assumption)

Total State Spending	$147,000,000
Total Federal Spending	$2.8 Billion
Total Spending	$2,947 Billion
Percent Federal Spending	95%

Source: Holahan, J. & I. Headen. Medicaid Coverage & Spending in Health Reform: Nat'l. & State-By-State Results at or below 133% FPL. May 2010. Urban Institute.

Public Program Expansion and Eligibility
Change in Spending Estimates

Medicaid Expansion to 133% Change in Total Spending (In Millions
(Lower Participation Assumption)

Total Spending 2014-2019										
Baseline Spending (In millions)			New Spending in Reform (In millions)			% Change in Spending			Federal Matching Rate	
State Spending	Federal Spending	Total Spending	State Spending	Federal Spending	Total Spending	State Spending	Federal Spending	Total Spending	Baseline	Effect Post Reform
$10,672	$17,886	$28,558	$147	$2,800	$2,947	1.4%	15.7%	10.3%	62.6%	65.7%

Source: Holahan, J. & I. Headen. Medicaid Coverage & Spending in Health Reform: Nat'l. & State-By-State Results at or below 133% FPL. May 2010. Urban Institute. Available: http://www.kff.org/healthreform/8076.cfm

Coverage & Cost
Immediate Impacts

- $5 Billion in federal funds to states for **High Risk Pools** (through 2013).
- **Retiree reinsurance subsidy** for employers who provide coverage to early retirees. (Pays 80% of claims costs between $15K & $90K annually, to a nation side total of $5 Bil.
- Internet portal geared to providing information on insurance options to individual & small businesses.
- Health plan disclosure and transparency requirements
- Patients can’t be charged increased cost sharing for obtaining emergency care from an out of network provider

High Risk Pools
U.S. & Iowa

- Temp. high risk pools w/in 90 days of enactment ($5 Bil. in federal funds).
- Eligibility:
  - ✓ Persons with pre-existing conditions, &
  - ✓ Uninsured for 6 months or more.
- **Iowa has chosen to run a pool alongside its existing pool.**
- Purpose of new Iowa pool – provide new source of coverage to the "uninsurable" because of pre-existing condition.
  - ✓ The new pool is not meant to replace or substitute for the existing pool.
- **Fairness Issue**
  - ✓ The pool will have a less expensive premium.
  - ✓ Existing pool members would have to give up coverage for 6 months in order to join the new, less expensive pool.

Coverage & Costs:
Immediate Impacts Cont.

- No **lifetime limits** on the dollar value of coverage (no annual coverage limits after 2014).
- Bars plan **rescissions** except in cases of fraud/material misrepresentation.
- Plans required to cover **recommended preventative services & immunizations** without any cost sharing.
- No pre-existing condition exclusions for children under 18.

- Extends adult child coverage to age 26 on parental policy.

Coverage & Costs:
Immediate Impacts - Small Business Tax Credits

- **Small Business Tax Credits – 2010-2013**

  ✓ Eligibility: < 25 employees & ave. wage < $50,000.

  ✓ Full credit for employers with 10 or fewer employees. & average wages less than $25,000

  ✓ Employer pays at least 50% of premium.

  ✓ Maximum credit is 35% of premium (25% for small non-profits)

- **2014 – credit available to small business for the first two years employees are offered a plan through an Exchange.**

Coverage:
Later Impacts – 2014, Cont.

- Small group & individual plans required to offer an “essential health benefits package.”
- Bar on pre-existing condition exclusion & restrictions on rating variations in premiums
  - ✓ Family structure, geography, Age (3:1 ratio), tobacco use (1.5:1 ratio)
- Individuals required to have minimum essential coverage (individual/group plan).
  - ✓ Exceptions for religious objectors, individuals below tax filing threshold, not covered < 3 months.
  - ✓ Penalties for non-coverage
    - 2014 – $95
    - 2016 – $695

2014 – Health Insurance Exchanges
Basic Provisions

- State established **American Health Benefit Exchanges**
  - ✓ For use in purchasing **individual coverage** for individuals/families.
- Separate state-based **Small Business Health Options Programs** (SHOP) exchanges (≤ 100 employees)
  - ✓ States will be allowed to combine the 2 exchanges.
  - ✓ After 2016, states can open exchanges to business with > 100 employees.
- If a state fails to establish an exchange, HHS will establish one for the jurisdiction.
  - ✓ By Jan. 1, 2013 states have to demonstrate they will have an operational exchange by Jan. 1, 2014.
- Exchanges can be administered by a governmental agency or a non-profit entity.

2014 – Health Insurance Exchanges
Primary Roles

- Certify plans that can be offered for sale on an exchange
- Rate plans on quality & cost.
  - ✓ HHS to develop minimum benefit standards
  - ✓ States allowed to require benefits beyond the minimum standard, but will be required to pay the extra costs for persons receiving coverage subsidies.
- Facilitate plan comparison & purchase by individuals & small employers.
- Mechanism for administering refundable tax credits for individual market purchasers
- Assist eligible persons in enrolling in public coverage.
- Certify persons for exemption from individual mandate.

Health Insurance Exchanges
Additional Provisions

- **Funding**
  - ✓ Grants will be provided by HHS to start-up exchanges.
  - ✓ By 2015 exchanges required to be self-sustaining.
- **Benefit Packages**
  - ✓ All plans required to provide basic services.
  - ✓ 4 benefit packages will be available, based on actuarial value (60%, 70%, 80% & 90%).
  - ✓ States may require a more expansive package of covered benefits.
  - ✓ Catastrophic plans will be available for young adults.

Health Insurance Exchanges
Co-Ops & Interstate Health Care Choice Compacts

- Federal dollars will be available to help establish non-profit, member run "Consumer Operated & Oriented Plan" (Co-Op).

  ✓ Co-Ops will offer Qualified Health Plans.

- HHS Sec. will issue regulations for "Interstate health Care Choice Compacts.

  ✓ Compacts will be allowed to offer "Qualified Health Plans" in all participating states.

  ✓ States have to have joint agreements

  ✓ Consumer protection of enrollees state of residency apply.

Delivery System & Payment Reform:
Value Based Purchasing

- 2013 – Hospital payments will be based partly on quality
- 2015 – Medicare gets a new MD payment method the "**Value Index**."
- Medicare will reduce payments to hospitals that have high rates of **readmissions** and **hospital acquired conditions**.

Delivery System & Payment Reform:
Quality Measurement & Reporting

- New incentives for providers to participate in the **Physician Quality Reporting Incentive Program**.
- In Medicare: MDs will have access to comparative reports on resource use and quality.
- Expanded **public reporting** of provider-specific quality data
  - Includes data on hospital readmission & hospital acquired condition rates
- Provides funding for development of **new quality measures**.

Delivery System & Payment Reform:
Improvements in System Accountability

- 2012 – Accountable Care Organization (ACO) **demonstration projects** will provide shared savings for ACOs that meet quality standards.
- Creation of the **Center for Medicare & Medicaid Innovation** to test new payment & service delivery models & reduce health care costs.